



Complete Summary

GUIDELINE TITLE

Focal neurologic deficit.

BIBLIOGRAPHIC SOURCE(S)

Wippold FJ II, Lacey JL, Seidenwurm DJ, Davis PC, Brunberg JA, De La Paz RL, Dormont PD, Hackney DB, Jordan JE, Karis JP, Mukherji SK, Turski PA, Zimmerman RD, McDermott MW, Sloan MA, Expert Panel on Neurologic Imaging. Focal neurologic deficit. [online publication]. Reston (VA): American College of Radiology (ACR); 2006. 13 p. [96 references]

GUIDELINE STATUS

This is the current release of the guideline.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [May 23, 2007, Gadolinium-based Contrast Agents](#): The addition of a boxed warning and new warnings about the risk of nephrogenic systemic fibrosis (NSF) to the full prescribing information for all gadolinium-based contrast agents (GBCAs).

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

SCOPE

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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES

SCOPE

DISEASE/CONDITION(S)

Focal neurologic deficit

GUIDELINE CATEGORY

Diagnosis
Evaluation

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Neurology
Radiology

INTENDED USERS

Health Plans
Hospitals
Managed Care Organizations
Physicians
Utilization Management

GUIDELINE OBJECTIVE(S)

To evaluate the appropriateness of initial radiologic examinations for patients with focal neurologic deficit

TARGET POPULATION

Patients who present with a focal disorder of motor or sensory function caused by intracranial pathology

INTERVENTIONS AND PRACTICES CONSIDERED

1. Magnetic resonance imaging (MRI), head
 - Without contrast
 - Without and with contrast
 - Functional (fMRI)
2. MR angiography (MRA), head and neck
3. MR spectroscopy (MRS)
4. Computed tomography (CT), head
 - Without contrast
 - With contrast

- Without and with contrast
- 5. CT angiography (CTA), head and neck
- 6. Invasive (INV), catheter cerebral angiography
- 7. Nuclear medicine
 - Single-photon emission computed tomography (SPECT), hexamethylpropyleneamine oxime (HMPAO)
 - SPECT, thallium
- 8. Positron emission tomography (PET)
- 9. X-ray, skull

MAJOR OUTCOMES CONSIDERED

Utility of radiologic examinations in differential diagnosis

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed literature searches of peer-reviewed medical journals and the major applicable articles were identified and collected.

NUMBER OF SOURCE DOCUMENTS

The total number of source documents identified as the result of the literature search is not known.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

One or two topic leaders within a panel assume the responsibility of developing an evidence table for each clinical condition, based on analysis of the current literature. These tables serve as a basis for developing a narrative specific to each clinical condition.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Since data available from existing scientific studies are usually insufficient for meta-analysis, broad-based consensus techniques are needed for reaching agreement in the formulation of the appropriateness criteria. The American College of Radiology (ACR) Appropriateness Criteria panels use a modified Delphi technique to arrive at consensus. Serial surveys are conducted by distributing questionnaires to consolidate expert opinions within each panel. These questionnaires are distributed to the participants along with the evidence table and narrative as developed by the topic leader(s). Questionnaires are completed by participants in their own professional setting without influence of the other members. Voting is conducted using a scoring system from 1-9, indicating the least to the most appropriate imaging examination or therapeutic procedure. The survey results are collected, tabulated in anonymous fashion, and redistributed after each round. A maximum of three rounds is conducted and opinions are unified to the highest degree possible. Eighty percent agreement is considered a consensus. This modified Delphi technique enables individual, unbiased expression, is economical, easy to understand, and relatively simple to conduct.

If consensus cannot be reached by the Delphi technique, the panel is convened and group consensus techniques are utilized. The strengths and weaknesses of each test or procedure are discussed and consensus reached whenever possible. If "No consensus" appears in the rating column, reasons for this decision are added to the comment sections.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Criteria developed by the Expert Panels are reviewed by the American College of Radiology (ACR) Committee on Appropriateness Criteria.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

ACR Appropriateness Criteria®

Clinical Condition: Focal Neurologic Deficit

Variant 1: Multiple focal neurologic deficits.

Radiologic Exam Procedure	Appropriateness Rating	Comments
MRI, head, without and with contrast	8	Consider increased contrast dose for problem solving in selected cases. Include diffusion weighted imaging.
MRI, head, without contrast	7	Include diffusion weighted imaging.
CT, head, without contrast	7	Acute screening.
MRA, head and neck	6	For suspected vascular abnormality.
CT, head, without and with contrast	6	If MRI unavailable or contraindicated.
CTA, head and neck	6	For suspected vascular abnormality.
MR spectroscopy (MRS)	4	For selected cases.
fMRI, head	3	
NUC, SPECT, HMPAO	3	For problem solving in HIV/AIDS.
NUC, SPECT, thallium	3	For problem solving in HIV/AIDS.
INV, catheter cerebral angiography	3	For problem solving.
PET	2	
X-ray, skull	1	
<p style="text-align: center;">Appropriateness Criteria Scale 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate</p>		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 2: Single focal neurologic deficit, sudden onset, stable, or incompletely resolving.

Radiologic Exam Procedure	Appropriateness Rating	Comments
MRI, head, without contrast	8	Include diffusion weighted imaging.
MRI, head, without and with contrast	8	Include diffusion weighted imaging.
CT, head, without contrast	8	For suspected hemorrhage.
MRA, head and neck	7	
CTA, head and neck	7	
CT, head, with contrast	5	Consider CT perfusion.
MR spectroscopy (MRS)	4	
fMRI, head	3	
NUC, SPECT, HMPAO	3	For problem solving in HIV/AIDS.
INV, catheter cerebral angiography	3	For problem solving.
PET	2	
NUC, SPECT, thallium	2	For problem solving in HIV/AIDS.
X-ray, skull	1	
<p align="center"><i>Appropriateness Criteria Scale</i> 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate</p>		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 3: Single focal neurologic deficit, sudden onset, progressive.

Radiologic Exam Procedure	Appropriateness Rating	Comments
MRI, head, without contrast	8	Include diffusion weighted imaging.

Radiologic Exam Procedure	Appropriateness Rating	Comments
MRI, head, without and with contrast	8	Include diffusion weighted imaging.
CT, head, without contrast	8	Screening for hemorrhage.
MRA, head and neck	7	
CTA, head and neck	7	
CT, head, without and with contrast	6	Consider CT perfusion.
MR spectroscopy (MRS)	4	
fMRI, head	3	
NUC, SPECT, HMPAO	3	For problem solving in HIV/AIDS.
NUC, SPECT, thallium	3	For problem solving in HIV/AIDS.
INV, catheter cerebral angiography	3	For problem solving.
X-ray, skull	1	
PET	1	
<p align="center"><i>Appropriateness Criteria Scale</i> 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate</p>		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 4: Single focal neurologic deficit, completely resolving.

Radiologic Exam Procedure	Appropriateness Rating	Comments
MRI, head, without contrast	8	Include diffusion weighted imaging.
MRI, head, without and with contrast	8	Include diffusion weighted imaging.
CT, head, without contrast	8	Screening for hemorrhage.
MRA, head and neck	7	

Radiologic Exam Procedure	Appropriateness Rating	Comments
CTA, head and neck	7	
CT, head, without and with contrast	6	Consider CT perfusion.
fMRI, head	3	
MR spectroscopy (MRS)	3	
NUC, SPECT, HMPAO	3	For problem solving in HIV/AIDS.
NUC, SPECT, thallium	3	For problem solving in HIV/AIDS.
INV, catheter cerebral angiography	3	For problem solving.
X-ray, skull	1	
PET	1	
<i>Appropriateness Criteria Scale</i> 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 5: Unexplained acute confusion or altered level of consciousness.

Radiologic Exam Procedure	Appropriateness Rating	Comments
MRI, head, without contrast	8	Include diffusion weighted imaging.
CT, head, without contrast	8	Screening for hemorrhage.
MRI, head, without and with contrast	7	Include diffusion weighted imaging.
MRA, head and neck	6	For suspected vascular abnormality.
CTA, head and neck	6	For suspected vascular abnormality.
CT, head, without and with contrast	5	If MRI unavailable or contraindicated. Consider CT perfusion.
fMRI, head	3	

Radiologic Exam Procedure	Appropriateness Rating	Comments
MR spectroscopy (MRS)	3	
PET	3	
NUC, SPECT, HMPAO	3	
NUC, SPECT, thallium	3	
INV, catheter cerebral angiography	2	
X-ray, skull	1	
<p align="center"><i>Appropriateness Criteria Scale</i> 1 2 3 4 5 6 7 8 9 1 = Least appropriate 9 = Most appropriate</p>		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Introduction

A focal neurological deficit consists of a set of symptoms or signs in which causation can be localized to an anatomic site in the central nervous system. The site of the pathologic abnormality is typically deduced through the history and physical examination prior to imaging. The clinical localization of a suspected lesion is extremely useful (and should be encouraged on the part of the examining physician) in that it assists the radiologist in directing the imaging portion of the evaluation. Focal neurological deficits may develop suddenly or may evolve chronically. Once a deficit occurs, it may remain stable, continue to worsen in a continuous or step-like fashion, or resolve. Resolution may be partial or complete.

Additionally, deficits may be unifocal, implying a single lesion, or multifocal, suggesting multiple discrete lesions. A patient presenting with a focal neurological deficit should be considered for imaging of the entire neuraxis. The presentation may suggest causation. For example, an acute temporal course prompts evaluation for cerebral infarction, but a more chronically progressive course is often due to a mass lesion. Specific disease entities are fully reviewed in separate ACR Appropriateness Criteria® sections. The patient who presents with a focal disorder of motor or sensory function caused by intracranial pathology is addressed in this summary.

Acute Focal Neurological Deficit

The sudden development of a focal neurological deficit suggests a vascular ischemic event such as an infarction. Infarctions typically remain stable in the immediate period of presentation or worsen due to complicating hemorrhage or edema. A deficit from a transient ischemic attack resolves within 24-hours.

Neurologic deficits from acute reversible ischemia may take up to 30-days to completely resolve. CT scanning is often used to screen patients for suspected infarction, but it may miss early cytotoxic edema. An obscured insular ribbon and a dense middle artery are signs indicating infarction but may be absent in a given patient. Diffusion weighted (DW) MR imaging detects cytotoxic edema in the first few hours of an infarction and may remain positive for a week to ten days. Spin echo sequences before and after intravenous enhancement may add significant information as the infarction evolves. A detailed summary of ischemic vascular disease is the subject of another Appropriateness Criteria® topic.

An intracerebral hemorrhage may also cause sudden onset of focal findings. The clinical examination may help to define the cause of the hemorrhage. A pupil involving third cranial nerve palsy associated with headache, for example, suggests subarachnoid hemorrhage due to aneurysm rupture. Sudden hemiparesis in the setting of hypertension suggests a hemorrhage in the basal ganglia. CT is generally the preferred modality for initial screening for intracranial hemorrhage because of its availability, rapid scanning time, and sensitivity in detecting blood. Recently, MR imaging has been found to be sensitive for both acute and chronic blood products and, when available, can exclude hemorrhage in patients with a suspected infarction before intravenous administration of tissue plasminogen activator (tPA). Moreover, MR imaging has been shown to be superior to CT in detecting acute petechial hemorrhagic transformation in acute ischemic stroke. A study showed that with appropriate sequence selection, acquisition time of an MR scan can be significantly decreased to about 10 to 15 minutes.

Traumatically induced or spontaneous subdural and epidural hematomas may also produce acute focal deficits. CT is the modality of choice for screening patients for suspected extraaxial hemorrhage.

Chronic Progressive Focal Neurologic Deficit

Chronically worsening focal neurological deficits may be caused by an expanding intracranial lesion such as a primary or metastatic neoplasm. Subacute or more rapidly developing symptoms may be caused by an infectious lesion. Primary and secondary neoplasms and abscesses may produce progressive weakness, impaired speech, personality change, or a sensory deficit, depending on the location within the brain. Hemiplegia is the most common form of paralysis. Monoplegia and, less commonly, bilateral weakness may also be caused by an intracranial mass lesion. The latter is usually caused by cord compromise, but occasionally brain stem or cerebral pathology produces bilateral symptomatology. The cardinal signs of a mass lesion include headache, vomiting, and papilledema. This triad is usually caused by obstructive hydrocephalus or marked peritumoral vasogenic edema. Cranial nerve deficits accompanying contralateral weakness localize pathology to the brainstem.

Imaging studies are performed primarily to exclude an intracranial mass lesion, whether neoplastic, infectious, or vascular, and to characterize the offending pathology. These patients should undergo imaging evaluation after physical examination.

CT is invaluable for detecting intracranial tumors, infections, and vascular lesions. A retrospective review found that 20% of elderly patients (>70 years of age) presenting with neurological deficits had treatable lesions discovered with CT. The cohort most affected by the CT imaging was the group with neurological signs that were atypical of stroke and with unexplained confusion or altered sensorium.

It is well established that contrast agents yield additional information on CT. An increase in the iodine dose can reveal new lesions and can further increase the conspicuity of some lesions, sometimes yielding supplementary diagnostic information. Current-generation scanners have significantly improved sensitivity; however, some pathology is difficult to visualize with CT under any circumstances. This is especially true for white matter disease and other lesions that may not produce significant mass effect. Also, compared with its ability to detect intraparenchymal lesions, CT is not as reliable for delineating leptomeningeal or dural disease. Moreover, it is unlikely to be of any benefit in atraumatic patients with neurological deficits that have completely resolved at the time of imaging.

Enhanced MR imaging is more sensitive than CT for detecting primary and secondary brain lesions and for defining the extent of disease. Even before the availability of MR imaging contrast agents, this modality surpassed CT in sensitivity for detecting intraparenchymal pathology. In addition to superior contrast resolution, MR imaging allows multiplanar acquisition and spares patients exposure to potentially damaging ionizing radiation. MR imaging also provides information that is unavailable by other noninvasive means, and sometimes it approaches the accuracy of a neuropathologic diagnosis. Intravenous gadolinium contrast especially increases the detection of intracranial metastatic disease. Whereas contrast agents allow the detection of metastases that are occult on unenhanced studies, virtually all primary brain neoplasms seen on enhanced images will also be identified on unenhanced sequences. Contrast agents aid the characterization of primary brain tumors, but they may not be essential for screening examinations. Stratification of patients who should receive contrast based on age may be beneficial. Metastatic disease affects all age groups, but the incidence increases significantly after the fourth decade. More than 75% of patients harboring central nervous system (CNS) metastases are between 40 and 70 years of age. Gadolinium is better tolerated than iodine, so some centers follow an unenhanced CT with a subsequent unenhanced and enhanced MR scan.

High-dose enhanced MR imaging results in increased lesion contrast, apparent size, and border definition compared with single-dose examinations. The administration of triple-dose MR contrast agents often reveals more lesions than does a single dose. High-dose MR imaging is more sensitive for the detection of intracerebral metastases than delayed standard dose MR imaging. Because there is evidence that resection of a solitary metastatic lesion (or a small number of lesions) improves patient survival, detection of a solitary lesion versus multiple lesions is likely to impact patient management. There is little argument that patients considered for surgical resection of a solitary metastatic nodule detected on noncontrast MR imaging studies or enhanced CT should undergo an enhanced MR imaging examination to exclude the presence of additional lesions. Certain patients may benefit from triple-dose contrast.

MR imaging is especially useful for evaluating the posterior fossa, a region often less well visualized with CT because of artifact. A posterior fossa mass is

suspected in patients presenting with increased intracranial pressure, cerebellar signs, and/or cranial nerve deficits. Brain stem pathology is a potential source for concomitant extremity and cranial nerve deficits. Neoplasms, vascular lesions, and occasionally infections may involve the pons, midbrain, or medulla. Up to 22% of cavernous malformations occur in the brainstem. MR imaging is superior not only for detecting of brain stem lesions, but also for characterizing hemorrhagic residua. Brain stem ischemia is not uncommon in older adults, and it may rarely occur in children. Suspected brain stem and other posterior fossa pathologies argue strongly for MR imaging over CT because of CT artifact caused by adjacent bony structures. Enhanced MR imaging is also the modality of choice for patients with cranial neuropathy.

While CT may be preferable for evaluating bony trauma, acute subarachnoid blood, and some head and neck disorders, MR imaging has become the modality of choice for most central nervous system disorders. Of course, nonavailability of MR imaging, MR incompatible life support apparatus, ferromagnetic aneurysm clips, and other contraindications to MR imaging will prompt CT even for diseases best evaluated with MR. Hemorrhagic lesions are characterized more accurately with MR. Although it is often impossible to distinguish tumoral hemorrhage from other causes on CT, features are often detected on MR imaging which suggest an underlying malignancy. Although CT is more sensitive for the detecting small calcifications associated with vascular malformations, MR is more sensitive for the detecting the small hemorrhagic foci that are commonly associated with vascular malformations, and it provides a more specific imaging appearance.

Despite the high resolution of MR imaging, the anatomic images may be insufficient for neurosurgeons who are contemplating resection of a lesion that borders eloquent cortex. Distortion of the motor strip and other vital parenchyma may occur secondary to an expanding adjacent mass. The functional plasticity of the brain may not be reflected on conventional anatomic imaging studies. Preoperative (or preradiation) functional MR imaging for mapping of eloquent cortex more precisely delineates motor and speech areas and may contribute to surgical and treatment planning. Such studies may supplant or accompany intraoperative neurophysiological testing for mapping the motor strip prior to resection of brain tumors. Additional functional information can be provided by diffusion tensor tractography. This method is being used in some centers for mapping the deflection of fibers carrying eloquent signals in the vicinity of the contemplated surgical bed. Such functional studies may also obviate amyntal testing.

In previously treated patients with brain neoplasms presenting with new neurological complaints, distinguishing radiation necrosis from tumor recurrence is a diagnostic challenge. These lesions, which may have a similar appearance on enhanced MR imaging, call for significantly different clinical management. Nuclear medicine SPECT or PET studies may provide improved specificity. However, these modalities are not universally reliable for making this distinction. MR spectroscopy may also prove useful for distinguishing radiation necrosis from tumor recurrence. Catheter angiography has traditionally been used to assess tumor vascularity. More recently, evaluation of tumor vascularity using dynamic MR imaging has been validated.

Localized infection may also produce focal neurological signs and symptoms. Neurological deficits due to infection tend to evolve more quickly than those due to tumor. Patients with parenchymal infectious lesions often have no fever or other systemic signs of infection, and may have a normal cerebrospinal fluid profile; if fever is present, it is nonspecific. Brain abscesses may result from a wide variety of organisms, including gram positive and gram-negative bacteria and various fungi. Blood-borne abscesses may develop in the brain as a result of cyanotic heart disease, pulmonary anterior-venous fistula, or bacterial endocarditis. Direct spread of organisms may also result in brain abscesses as a complication of sinusitis, chronic otitis or mastoiditis, and post-traumatic or congenital transgression of the dura. Intracerebral abscesses may also develop by direct venous spread from extradural infections. An early diagnosis of a brain abscess or its earlier stage of "cerebritis" guides appropriate treatment, including the careful selection of antibiotics, drainage of the abscess cavity, and correction of the original source of the infection, particularly if the abscess is secondary to sinus or middle ear infection.

Since the introduction of CT, the overall mortality rate of abscesses has decreased from more than 40% to less than 5%. The CT appearance of infectious masses has been well described. Earlier detection in combination with improved therapeutic measures for intracranial infections has produced a significant decrease in complications such as extension to extra-axial spaces, hemorrhage, infarction, compartmental herniation, and death. Although it is less sensitive for detecting small calcifications, MR imaging provides greater sensitivity for assessing intracranial abscess and granulomas, and may be more specific. However, even in endemic areas, the imaging appearance of such lesions is not specific enough to obviate histological confirmation before treatment.

Contrast enhanced images augment the sensitivity of CT and MR brain imaging. The efficacy of enhanced MR scans has been demonstrated in children and adults. MR imaging is superior to CT for evaluating parenchymal abscesses and their complications. It is also more sensitive for evaluating extra-axial infection. MR imaging demonstrates almost pathognomonic findings in a mature abscess due to the shortening of the T1 and T2 relaxation times in the abscess wall, resulting in hyperintensity on T1-weighted and hypointensity on T2-weighted images. Diffusion-weighted MR imaging may allow differentiation of brain abscess from necrotic or cystic brain tumors. The ring configuration seen in tumor on spin echo sequences aids in differentiating the finding from the solid, central restricted diffusion seen in abscess. The restricted diffusion found in extradural epidermoids may be confused with empyema, but correlation with spin echo images and clinical findings is useful. MR imaging, and particularly MR venography (MRV), may also be useful for demonstrating secondary venous occlusive disease, a frequent complication of chronic mastoiditis with superimposed acute infection. Despite advances in MRV, catheter cerebral angiography remains the "gold standard."

CT is considered superior for demonstrating bone abnormalities in inflammatory ear disease and may also provide useful additional information in cases of sinusitis. CT remains the standard modality for diagnosing sinusitis, but MR imaging is often necessary to exclude intracranial complications of sinusitis such as meningitis or abscess. CT or MR imaging is also necessary for stereotactic aspiration of abscess cavities. MR spectroscopy may be useful for demonstrating

abscesses because specific resonance lines have been shown in the contents in the abscess. Several studies have suggested the value of triple-dose contrast with MR imaging for increasing the conspicuity of abscesses. Conspicuity may be further enhanced by magnetization transfer imaging techniques, although the latter has not been widely adopted in everyday practice.

Patients infected with HIV and those with AIDS exhibiting focal neurological symptoms should undergo cranial imaging in order to guide clinical management. In addition to contributing to clinical management, imaging findings also have prognostic implications in AIDS patients. The presence of focal lesions or atrophy significantly increases the risk of death in patients with AIDS when compared to AIDS patients with normal neuroimaging examinations. The risk is even greater if both focal lesion and atrophy are present. The treatment for the most common intracranial lesions in these patients must be instituted promptly. MR imaging is superior to CT for detecting white matter lesions and vasogenic edema. Despite the excellent capacity of MR imaging to delineate lesions, distinguishing between lesions caused by toxoplasmosis and primary CNS lymphoma is often difficult on the basis of anatomic imaging alone. Some MR imaging features may favor one diagnosis over the other, but the distinction is often difficult. Although enhanced images have been shown to provide additional information in AIDS patients who present for cranial MR imaging, the value of routine use of gadolinium contrast agents in AIDS patients has been challenged.

Thallium-201 uptake of lymphoma may be exploited by performing SPECT on AIDS patients presenting with intracranial lesions. Characterizing biochemical profiles of lesions using H-1 spectroscopy may provide another noninvasive, and more specific method for differentiating these lesions. Additional information may be obtained from perfusion MR imaging. Reduced regional cerebral blood volume (rCBV) in toxoplasmosis lesions has been described compared with increased rCBV in lymphomas, thus allowing differentiation of mass lesions in AIDS patients caused by these diseases.

Chronic subdural hematomas may also produce a step-wise progressive neurological deficit if repetitive rebleeding has occurred. CT is the modality of choice for screening in this circumstance.

Fluctuating Focal Neurological Deficit

Focal neurological deficits that have a stuttering course or localize to multiple locations may be clinically challenging. One cause is demyelination, most commonly caused by multiple sclerosis (MS). MS is an inflammatory disease that primarily affects central myelin, secondarily injuring axons and their neurons of origin. Although the mechanisms of injury are still being clarified, MS is considered an organ-specific autoimmune disease. Through a variety of possible mechanisms, including viral infection, a clone of T-cell lymphocytes becomes sensitized to specific myelin peptides. Relapses occur when the activated T-cell lymphocytes increase endothelial cell permeability and recruit macrophages, astrocytes, and other cells to cause focal inflammation and myelin destruction. Recently, the management of this disorder has been radically changed by the availability of drugs that are effective in improving the natural course of the relapsing-remitting form.

When considering the appropriateness of imaging procedures for diagnosing MS, important factors include: 1) the likelihood that a given clinical presentation represents demyelinating disease or other disorder that can be imaged, and 2) the likelihood that the use of an imaging modality will change the management of the disorder. Up to 40% of patients with proven MS first present with paresthesias or other vague sensory symptoms. Pain can also be the first symptom. These patients often have negative MR imaging of the brain and spinal cord. Pursuing imaging beyond the standard screening MR imaging may not be indicated.

The sensitivity of CT of the brain for MS is low. Indirect findings, such as areas of hypodensity or brain atrophy, appear late in the disease and are nonspecific. MR imaging revolutionized the diagnosis and management of MS, which previously was diagnosed solely by clinical criteria and CSF analysis. Poorly detected by CT, MS is clearly depicted by MR imaging. In a study comparing high field MR imaging (1.5T) to low field MR imaging (.23T), it was shown that high field studies are far superior for diagnosing MS. As promising new therapies for MS were evaluated in the early 1990s, it became clear that MR imaging was more sensitive to disease activity than the neurological evaluation, thus allowing for smaller sample sizes and, thereby, for more economical and faster therapeutic trials.

Because of its greater sensitivity for detecting edematous lesions next to CSF-filled spaces, fluid-attenuated inversion recovery (FLAIR) with fast spin-echo acquisition is quickly becoming a standard sequence in clinical MR imaging. In earlier studies, FLAIR images were found to be more sensitive for cord MS lesions than conventional T2-weighted images.

Large studies on the sensitivity and specificity of MR imaging for MS have used conventional MR imaging sequences. In a study of 303 patients referred because of the suspicion of MS, a "definite MS" reading on an MR imaging of the head was specific for MS (likelihood ratio, 24.9) and established the diagnosis, especially in patients clinically designated as probable MS before testing. However, MR imaging of the head was negative for MS in 25% and equivocal in 40% of the patients considered to have MS by the diagnostic review committee reviewing each patient's course after a 6-month follow-up. Studies of clinically definite MS yielded sensitivity for MR imaging of 70% to 83%. Many of the patients with negative brain studies may have had spinal cord lesions that were undetected because the spinal cord was not systematically surveyed. In a group of 170 MS patients with symptoms and signs referable to the spinal cord or optic nerves, 20 (12%) had normal brain MR imaging. Patients with a myelopathy often have brain lesions on MR imaging. Even in early studies, MR imaging was found to be more sensitive than CSF oligoclonal banding for the diagnosis of MS. MR imaging was also more sensitive than neurophysiological evoked response studies.

Brain MR imaging has been used in large therapeutic trials to monitor MS disease activity. In relapsing-remitting and secondary progressive MS, serial T2-weighted MR imaging reveals 3 to 10 times as many new lesions as there are clinical relapses. Gadolinium enhancement further increases the reliability and sensitivity of detecting active lesions. The sensitivity of MR imaging for detecting active brain lesions can be increased by injecting larger doses of contrast material, up to 0.3 mmol/kg (triple dose). In relapsing-remitting and secondary progressive MS, the presence of enhancement is more frequent during relapse and correlates well with clinical activity. Enhancement is rare in primary progressive MS. In benign MS,

with a slow progression and little disability, enhancing lesions are also rare. Delayed scanning and magnetization transfer may improve sensitivity.

MR spectroscopy may help clarify the pathophysiology underlying the diverse varieties of MS. Metabolic changes have been observed on MR spectroscopy before the appearance of lesions on MR imaging, but these applications have little application in clinical practice at this time.

Abbreviations

- AIDS, acquired immunodeficiency syndrome
- CT, computed tomography
- CTA, computed tomography angiography
- fMRI, functional magnetic resonance imaging
- HIV, human immunodeficiency virus
- HMPAO, hexamethylpropyleneamine oxime
- INV, invasive
- MR, magnetic resonance
- MRA, magnetic resonance angiography
- MRI, magnetic resonance imaging
- NUC, nuclear imaging
- PET, positron emission tomography
- SPECT, single-proton emission computed tomography

CLINICAL ALGORITHM(S)

Algorithms were not developed from criteria guidelines.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on analysis of the current literature and expert panel consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Selection of appropriate radiologic imaging procedures for evaluation of patients with focal neurologic deficit

POTENTIAL HARMS

Computed tomography (CT) is associated with potentially damaging ionizing radiation.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

An American College of Radiology (ACR) Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists, and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those exams generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the U.S. Food and Drug Administration (FDA) have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Wippold FJ II, Lacey JL, Seidenwurm DJ, Davis PC, Brunberg JA, De La Paz RL, Dormont PD, Hackney DB, Jordan JE, Karis JP, Mukherji SK, Turski PA, Zimmerman RD, McDermott MW, Sloan MA, Expert Panel on Neurologic Imaging. Focal neurologic deficit. [online publication]. Reston (VA): American College of Radiology (ACR); 2006. 13 p. [96 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006

GUIDELINE DEVELOPER(S)

American College of Radiology - Medical Specialty Society

SOURCE(S) OF FUNDING

The American College of Radiology (ACR) provided the funding and the resources for these ACR Appropriateness Criteria®.

GUIDELINE COMMITTEE

Committee on Appropriateness Criteria, Expert Panel on Neurologic Imaging

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Panel Members: Franz J. Wippold II, MD; Joanne L. Lacey, MD, David J. Seidenwurm, MD; Patricia C. Davis, MD; James A. Brunberg, MD; Robert Louis De La Paz, MD; Pr. Didier Dormont; David B. Hackney, MD; John E. Jordan, MD; John P. Karis, MD; Suresh Kumar Mukherji, MD; Patrick A. Turski, MD; Robert D. Zimmerman, MD; Michael W. McDermott, MD; Michael A. Sloan, MD, MS

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [American College of Radiology \(ACR\) Web site](#).

ACR Appropriateness Criteria® *Anytime, Anywhere*™ (PDA application). Available from the [ACR Web site](#).

Print copies: Available from the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191. Telephone: (703) 648-8900.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- ACR Appropriateness Criteria®. Background and development. Reston (VA): American College of Radiology; 2 p. Electronic copies: Available in Portable Document Format (PDF) from the [American College of Radiology \(ACR\) Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on September 6, 2006. This summary was updated by ECRI Institute on May 17, 2007 following the U.S. Food and Drug Administration (FDA) advisory on Gadolinium-based contrast agents. This summary was updated by ECRI Institute on June 20, 2007 following the U.S. Food and Drug Administration (FDA) advisory on gadolinium-based contrast agents.

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